Heart Vein & Vascular LLC
B. Alex Vakili M.D, F.A.C.C, F.S.C.A.I
Integrative Cardiovascular Private Clinic

2170 W State Road 434 Suite 190
Longwood, FL 32779
Phone: 407-990-1921 Fax: 407-990-1921
E-Mail: Suppor@heartveinvascular.com
Web: www.heartveinvascular.com

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed, and how you can access this information.

At Heart Vein & Vascular LLC, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you. You have the 1ight to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the tight to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter the earlier documents, but will add new information. You have the right to receive a report of whom we disclose your information to. If our privacy and security measures or systems are breached in any way, we will notify you. You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComp1aint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Nichole Richardson, (407) 990-1921, for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

I, _____ have received a copy of Heart Vein & Vascular LLC, notice of privacy policy practices.

_____

Signature of Patient or Legal Representative Date

Heart Vein & Vascular LLC

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PATIENT INSURANCE & CONFIDENTIAL INFORMATION

Patient Name _____ Date _____

Date of Birth _____ Social Security # _____ Female _____ Male _____

Email Address _____

Street Address _____ City _____ ZIP _____

Mailing Address _____ City _____ ZIP _____

Home Phone Number _____ Other Phone Number _____

Name of Employer _____ Occupation _____

Employer's Address _____ Phone Number _____

Name of Spouse _____ Phone umber _____

Spouse's Employer _____ Phone Number _____

Nearest Friend or Relative _____ Relationship _____

Address _____ Phone Number _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

INSURANCE YES NO

Medicare# _____ Medicaid# _____

Other Insurance Name _____

Group # _____ Policy# _____

Name of Insured _____ Relationship _____

Preferred Pharmacy _____ Pharmacy Location _____

Preferred Hospital _____ Hospital Location _____

Preferred Language English / Spanish / Other _____

Ethnicity Asian / African American / Hispanic / Middle Eastern / White / Other _____

RELEASE OF INFORMATION AND PAYMENT TO PHYSICIANS

In order to submit a claim for payment for covered services, we must have authorization to release medical Information to your insurance carrier.

MEDICARE AND MEDICAID

I certify that the Information given by me In applying for payment under Title XVIII of the Social Security Act Is correct I authorize any holder of medical or other information about me to release to the Social Security Administration or its Intermediaries or carriers any Information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my bel1alf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

ALL OTHER INSURANCE

I hereby authorize Heart Vein & Vascular LLC, to submit a claim to my insurance carrier or Its intermediaries, for all covered services rendered by the physician(s) and aud1orize and direct my Insurance carrier or its Intermediaries to Issue payment check(s) directly to the physician(s) rendering the covered services.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I authorize Heart Vein & Vascular LLC, Babak Alex Vakili MD, to use, disclose and furnish my personal health information, including but not limited to, information about the services rendered to me, as may be requested by my insurance carrier or its Intermediaries, and to those providers of Its treatment, payment, and health care operations and as described more fully In the Heart Vein & Vascular LLC written Notice of Privacy Practices which I have been provided a copy of.

I further agree that I am responsible for paying any balances, which remain after Insurance payments hove been made.

Patient Signature _____ Date _____

Spouse Signature _____ Date _____

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Patient Consent to Release of Records

PATIENT NAME:_____DATE:_____

DOB:_____ SOCIAL SECURITY#_____

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME_____YES_____NO

I AUTHORIZE Heart Vein & Vascular LLC TO RELEASE MY RECORDS IN THEIR ENTIRETY TO:

_____

_____

_____

PLEASE FAX RECORDS TO_____

Purpose of Disclosure:

( ) Continuing care with another physician or hospital ( ) Personal copy ( ) Other:_____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving tile revocation.
3. I may refuse to sign this authorization and that it is strictly voluntary.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. If I do not sign this form, my health care and the payment for my health care will not be affected.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature:_____Date:_____

Representative Signature:_____Date:_____

Relationship to Patient _____

Witness Signature:_____Date:_____

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Patient Consent to Obtain Records

PATIENT NAME:_____DATE:_____

DOB:_____ SOCIAL SECURITY#_____

DO YOU LIVE IN AN ASSISTED LIVING FACILITY OR A NURSING HOME_____YES_____NO

I AUTHORIZE THE FOLLOWING PHYSICIAN (S) AND/OR HOSPITAL (S) TO RELEASE MY RECORDS IN THEIR ENTIRETY OR AS INSTRUCTED BELOW, TO:

Heart Vein & Vascular LLC
2170 W State Road 434, Suite 190
Longwood, FL 32779
Tel: 407-990-1921
Fax: 407-990-1921 (same as phone #)
support@heartveinvascular.com

Heart Vein & Vascular LLC MAY ALSO ACCESS MY PATIENT PORTAL TO RETRIBVE NECESSARY RECORDS.

PLEASE FAX RECORDS TO: 407-990-1921 (Heart Vein & Vascular LLC)

Purpose of Disclosure:

( ) Continuing care with another physician or hospital ( ) Personal copy ( ) Other:_____

I understand that:

1. This authorization will remain in effect for 365 days
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving tile revocation.
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6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, or if I ask for it.
7. I will receive a copy of this form after I sign it.

Patient Signature:_____Date:_____

Representative Signature:_____Date:_____

Relationship to Patient _____

Witness Signature:_____Date:_____

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MEDICATION & ALLERGY RECORD

Patient Name _____ DOB _____ Date _____

ALLERGIES: _____

_____

PRESCRIPTION NAME	DOSE	FREQUENCY	NOTES

PREFFERED PHARMACY: _____
PHARMACY ADDRESS: _____
PHARMCAY TEL: _____
PHARMACY FAX: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date _____ Patient Name_____

By signing below, I acknowledge that I have received a copy of the HEART VEIN & VASCULAR LLC, Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Contact Information for Personal Representative:

Address:

_____

_____

Phone Number:

_____ _____

Daytime | Evening

I authorize HEART VEIN & VASCULAR LLC, to share my medical information with the following:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

This authorization will remain in effect from the date it is signed until I cancel it in writing.

By signing below, I acknowledge I have reviewed and understand this authorization form.

_____ _____

Patient Name | Date